



Indy Parks & Recreation Health / Therapeutic Assessment

For Park managers to fill out:

Referral: _____ (mgr name)

Program: _____

In order to provide your family with the most inclusive program possible, we ask that you complete a brief assessment. Please return this form with your program registration. This form is to be completed on a volunteer basis only in an effort to better serve the needs of your camper.

Parent/Guardian Name: _____ Daytime Phone: _____

Participant's Name: _____ Date of Birth: _____

Participant's: Sex: Male / Female Age: _____ Height: _____ Weight: _____

Weeks (and dates and time) enrolled at camp or program: _____

Health Information: Briefly indicate your child's disability, and what characteristics he/she presents.

Diagnosis: _____ Wheelchair assisted-Yes / No

- Motor Concerns (diapers, wheelchairs, etc): _____
- Recreational Concerns(glasses, feeding tubes): _____
 - Swimming Ability/water adjustment level, (use of lifejacket): _____
- Visual Concerns (glasses, blindness): _____
- Seizures (helmets): _____
- Hearing Concerns (hearing aides): _____
- Verbal or Nonverbal (language skills): _____
- Allergies (Bees, Food, etc.): _____
- Behavioral Concerns: _____
 - Please list successful calming techniques, please use the back of the sheet if needed: _____
- Feeding Concerns: (G-tube feeding? Special Diet? Braces): _____
 - Can your child take anything by mouth? Reflux? _____

Please note any precautions for participant care (i.e. transfers, shunts):

Does the participant present any of the following illnesses or symptoms? Please check all that apply. ☐Heart Disease ☐Diabetes ☐Asthma ☐Cancer ☐Seizures

If yes, please explain in detail, ie. type and frequency of seizures, etc.

Current Medications: Please be sure to indicate whether taken at home or at camp.

Medication/Name:	Dosage:	Frequency:	Time: am. pm, lunch, with a meal?

Please fax the assessment to Galen Daniels, Therapeutic Recreation Manager (317) 327-5568.